

Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices



NHS England INFORMATION READER BOX

Directorate

Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference: 01014

Document Purpose	---
Document Name	Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices
Author	NHS England
Publication Date	20 January 2014
Target Audience	CCG Clinical Leaders, Foundation Trust CEs , Medical Directors, Directors of PH, NHS England Regional Directors, NHS England Area Directors, NHS Trust Board Chairs, Directors of Finance, Communications Leads, NHS Trust CEs
Additional Circulation List	CCG Chief Officers, CSO Managing Directors
Description	This paper sets out how NHS England as direct commissioners and providers of NHS services can work together to create incentives that achieve both better outcomes for patients and result in efficiencies in the use of high cost drugs which are excluded from the national tariff.
Cross Reference	None
Superseded Docs (if applicable)	N/A
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Specialised Services Team NHS England Floor 5 Skipton House

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices.

NHS England principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices set in the National Tariff published on 17 December 2013 and directly commissioned by NHS England.

First published: January 2014

Prepared by: The Specialised Commissioning Medicines Optimisation Clinical Reference Group

Contents	Page
Executive summary.....	5
Introduction	6
Background.....	6
Why use incentive schemes?.....	7
Scope for savings.....	8
Criteria for local schemes for high cost drugs that are not reimbursed through national prices set out in the National Tariff	8
NHS England supports the continued use of these principles for incentive arrangements negotiated between the 10 area teams that commission specialised services and provider Trusts	9
Resourcing incentive schemes.....	9
Getting started.....	10
NHS England as the direct commissioner of some high cost medicines for the financial year 2014/15	10
NHS England 'incentive' arrangements from 1 April 2014	10

Executive summary

Purpose

This paper sets out how collaborative arrangements between NHS England (as the direct commissioner of “specialised” NHS services) and Trust providers of NHS services can work together to create incentives that achieve both better outcomes for patients and greater efficiencies in the use of medicines which are not reimbursed via national prices set out in the [National Tariff](#).

The 2014/15 National Tariff Payment System issued by NHS England and Monitor in December 2013 refers to incentive arrangements. The guiding principles set out in this document are the definitive principles agreed by NHS England as direct commissioners of specialised services and should be used by Specialised Commissioning area teams and provider trusts when agreeing their arrangements for medicines not reimbursed through national prices for 2014/15 and beyond.

Objectives

The high level principles outlined here are intended to support collaboration between NHS England as the commissioner and Trust providers in delivering their NHS Constitution obligations and in their introduction of the Compliance Regime for National Institute for Health and Care Excellence (NICE) Technology Appraisals.

Whilst this paper’s main objective is to describe how NHS England will incentivise provider trusts to ensure maximum value for money from medicines excluded from the National Tariff, clinical commissioning groups (CCGs) who also fund a number of medicines that are excluded from the National Tariff, could adopt the principles set out in section 14.

NHS England recognises that ensuring that all ‘incentive’ arrangements meet the principles set out in this document will not happen immediately. Sudden changes may destabilise Trust finances and therefore it is anticipated that movement towards compliance with the principles will be achieved over a two year period from April 2014.

Next steps

Area teams with responsibility for specialised commissioning should use this document to work with provider trusts to set out how the principles can be incorporated into local agreements.

Following on from the publication of this paper, the NHS England Specialised Commissioning Medicines Optimisation Clinical Reference Group (CRG) will produce a template proforma for proposed ‘gain share’ arrangements and a ‘top tips’ document aimed at outlining the potential efficiencies available around arrangements for high cost drugs excluded from the National Tariff.

Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices.

NHS England principles for sharing the benefits associated with more efficient use of high cost drugs not reimbursed through national prices set out in the National Tariff and directly commissioned by NHS England.

Introduction

1. This document sets out how NHS England as direct commissioners and providers of NHS services can work together to create incentives that achieve both better outcomes for patients and deliver greater efficiencies in the use of high cost drugs that are not reimbursed through national prices set out in the National Tariff (formerly drugs excluded from the Payment by Results (PbR) tariff). It is intended to support commissioners and providers in delivering their NHS Constitution obligations and in their introduction of the Compliance Regime for NICE Technology Appraisals.
2. Whilst this paper's main objective is to describe how NHS England will incentivise provider trusts to ensure maximum value for money from medicines that are not reimbursed through national prices set out in the National Tariff, CCGs, who also commission a number of such medicines, could adopt the principles set out in section 14 below.
3. NHS England recognises that ensuring that all 'incentive' arrangements meet the principles set out in this document will not happen immediately. Sudden changes may destabilise Trust finances and therefore it is anticipated that movement towards compliance with the principles will be achieved over a two year period from April 2014.

Background

4. The National Tariff maintains a list of both medicines that are approved for payment against the tariff price and a list of medicines that are excluded from payment by this route. For medicines that are not reimbursed through national prices set out in the National Tariff, commissioners and providers agree local arrangements for monitoring activity. Because acquisition costs are reimbursed by commissioners, there may be little incentive for a provider to maximise the cost-effectiveness of these treatments, particularly where providers have to make decisions on prioritisation of their resources or if improvements in cost-effectiveness require the commitment of additional resources.

5. In the Department of Health (DH) commissioned report *Homecare Medicines: Towards a Vision for the Future*¹, it was recommended that commissioners should ensure that as part of national or regional procurement arrangements for medicines, there are clear, up-front agreements on the share of financial savings with both commissioners and providers.

Why use incentive schemes?

6. Incentive schemes have worked well in changing prescribing behaviour in primary care and therefore, although there are some differences, it is logical to use a similar approach to produce efficiencies in other care settings where prescribing is taking place.
7. Over the last two or three years of their existence, primary care trusts (PCTs) had begun to adopt 'incentivising arrangements' commonly known as 'gain share' schemes to encourage secondary care providers to make the most efficient use of high cost drugs excluded from the then 'Payment by Results' tariff.
8. In November 2012, a paper outlining the principles of such 'gain share' arrangements was agreed at national level.²
9. NHS England is now responsible for reimbursing the majority of high cost medicines that are not reimbursed through national prices set out in the National Tariff and is currently looking at previous schemes with a view to delivering greater consistency across such arrangements for the financial year 2014/15.
10. Areas where changes in secondary care provider behaviours and/or activity which can produce significant efficiencies for the NHS (and hence worth incentivising) could include:
 - medicines use – e.g. prescribing a more cost effective alternative.
 - medicines procurement – e.g. entering into collaborative procurement arrangements for medicines.
 - medicines manufacture/preparation – e.g. moving to more effective operating strategies such as vial sharing or aseptic unit patient cohorting.
 - medicines supply – e.g. moving to alternative delivery arrangements, such as Homecare or outsourced outpatient dispensing.
 - medicines wastage - e.g. strategies to reduce injectable chemotherapy wastage.

All these areas have the potential to deliver benefits for patients, the public and the NHS. More detailed explanations and examples of schemes likely to produce efficiencies will be made available in a 'top tips' document being developed by the Medicines Optimisation Clinical Reference Group (CRG).

¹ Home Care Medicines - Towards a Vision for the Future. Mark Hackett CEO UHS NHS FT
<http://cmu.dh.gov.uk/homecare-medicines-review-group/>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127167/high-cost-drugs.pdf.pdf
(Gateway reference number: 18170)

11. Health economies may not make the best use of their resources and lose the opportunity to improve their quality of care unless they have agreements in place to ensure that providers actively seek the most clinically and cost effective medicines that are not reimbursed through national prices set out in the National Tariff. The NHS may therefore be paying for:

- more expensive treatments where clinically equivalent but more cost effective alternatives are available.
- medicines that have not been procured in the most cost effective way.
- medicines that could be delivered in a more cost effective way.

Scope for savings

12. Currently, it is estimated that approximately 60 per cent of the cost of medicines used by providers of secondary and tertiary care may be accounted for by medicines which fall outside the scope of the National Tariff. In England, the spend on medicines in hospitals in 2011 was around **£4.9 billion**³. Therefore, we can reasonably assume that the cost of drugs excluded from the National Tariff in England could be up to **£2.9 billion** per year. Some Trusts, especially tertiary care centres report that their 'tariff-excluded drugs' account for significantly more than 60 per cent of their total drug spend.

13. It is recognised that many Trusts across England have worked hard to ensure that high cost drugs are used as efficiently as possible. However, there remains significant variation across the country with areas where much more could be done. This paper aims to set out the principles by which local incentive arrangements should be agreed.

Criteria for local schemes for high cost drugs that are not reimbursed through national prices set out in the National Tariff

14. The nationally agreed work in 2012 outlined a number of criteria for successful 'gain share' agreements. Building on these principles, NHS England supports incentive arrangements that aim for the following:

- That processes developed to improve efficiencies in the cost effective use of medicines should maintain, if not improve, the quality of patient experience.
- Be simple and not overly bureaucratic.
- Result in reduced medicines wastage.
- Have senior (e.g. Director) level engagement and support in both the commissioning and providing organisations – not just seen as the domain of senior pharmacists.
- Have relevant clinicians engaged in the process at the earliest opportunity.
- Both commissioner and provider aim to see the wider picture of efficiencies.

³ Hospital Prescribing England 2012: Health and Social Care Information Centre

- Good working relations between commissioner and provider, pharmacy and finance departments.
- Any efficiencies and incentives appropriately reflect the work that pharmacy departments have to do in order to maximise the efficiencies available.
- Use simple data to set baselines e.g. cost per unit over the previous two years.
- Join up “gain sharing” with regional procurement, Home Care and QIPP initiatives to maximise the efficiencies that can be gained.
- Annual review to reflect changes in workload once new initiatives are bedded in, document progress and ensure that new priority areas are identified.
- Flexibility to be adapted on a scheme by scheme basis to ensure a “fair” gain for Providers.
- Open and transparent monitoring arrangements with absolute agreement on the baseline, data source and Key Performance Indicators (KPIs).
- Schemes should be developed in consultation with local CCGs to ensure there are no unintended consequences for primary care or unplanned impact on CCG commissioning arrangements with the Trust(s) in question.

NHS England supports the continued use of these principles for incentive arrangements negotiated between the 10 area teams that commission specialised services and provider Trusts

15. Pitfalls to avoid include:

- Adversely affecting patient experience.
- Entrenched positions on the detail of baselines or incentives.
- Adversarial relationships between commissioner and provider may mean that ‘gain sharing’ schemes are either not adopted or are not agreed and implemented in a ‘timely manner’ and therefore the overall spend is not managed or the maximum efficiency achieved.
- Agreeing to baseline pricing data is problematic and protracted discussions may prevent any savings from being realised.
- Surrounding CCGs being adversely affected e.g. creation of additional demand that has not been planned for.

Resourcing incentive schemes

16. A significant proportion of the work to release savings will fall to provider pharmacy teams. Providers should therefore consider that a proportion of any incentive arrangement should be used to resource pharmacy teams, infrastructure and information technology to undertake this role. The detailed arrangements are a matter for providers but they will be aware of the effect that insufficient capacity within pharmacy departments will have on their

ability to contribute effectively to the development and management of any schemes to deliver efficiencies.

Getting started

17. At the beginning, experience shows that the best way of making progress is to concentrate on the priority areas agreed between commissioner and provider, for example, focussing on quality, innovation, productivity and prevention (QIPP) medicines plans or areas identified as maximising value for money and/or addressing key medication safety issues. If agreeing areas to pursue is problematic, start simply with one therapeutic area that may be less controversial. Agreed schemes can be adopted in a variety of localities with minor alterations to process and no need to re-negotiate at length in each locality. Success in year one enables providers and commissioners to build in future years. A more detailed outline of schemes known to produce efficiencies will be produced by the NHS England Medicines Optimisation CRG in due course.

NHS England as the direct commissioner of some high cost medicines for the financial year 2014/15

18. NHS England had previously agreed that arrangements previously signed off by PCTs could continue for 2013/14. All such arrangements are currently under review. NHS England, in agreeing future 'gain share' arrangements (between the relevant area team and the provider Trust); will apply the criteria outlined in section 14 to ensure consistency and fairness across all Trusts in England.
19. Whilst some Trusts may have concerns regarding long standing arrangements, NHS England will require consistent arrangements across all Trusts. In cases where staff posts have been supported, these will continue to be funded where the posts have clearly demonstrated safety and/or efficiency benefits.
20. NHS England recognises that sudden changes in long standing arrangements could destabilise Trust finances and therefore will work with Trusts to ensure that compliance with the principles happens in a managed way and may take a period of two years from 2014.

NHS England 'incentive' arrangements from 1 April 2014

21. In addition to the criteria in section 14, the following principles should apply to any NHS England-approved incentive arrangements:

- Trusts and commissioners should work together to identify schemes that will deliver efficiencies. Savings should be fully transparent and agreement reached before the scheme is undertaken on how the benefits will be shared.
- At a regional level, area teams should work with regional procurement specialists to maximise the efficiencies available.
- Ideally, schemes should be undertaken across an area team region (and beyond) to produce consistency of price and access to treatments. However, NHS England recognises that this will take time to achieve and may take two years from April 2014. NHS England also recognises that it may not always be possible to achieve consistency of price despite providers' best efforts.
- Where a scheme creates additional administrative burden (usually to the pharmacy service) and is not directly linked to activity and hence a tariff payment e.g. provision on home delivery services, the commissioner and Trust should agree how any efficiency can be used to fund additional resource e.g. a pharmacy technician.
- Any efficiencies made on high cost medicines, will ultimately go back into supporting patient care to improve their health outcomes.
- The funds released may not necessarily be reinvested in the specialty/clinical area from which they were realised.
- All approved schemes should be formally 'signed off' by the area team director of finance and provider director of finance.
- All approved schemes should include a start and stop date to ensure all parties are clear about the arrangement. Arrangements can be rolled over after the stop date but that must be formally agreed.
- Schemes must **not** be linked to medicines that are part of clinical trials.
- Proposed schemes should be shared with local CCGs at the development stage to identify any issues of impact or consequence for local CCGs.
- The timescales for any agreement should be in line with the normal contract schedule and should entail: (a) initial discussion; (b) negotiation; (c) agreement and (d) implementation. The timetable will need to be coordinated with that of the Commercial Medicines Unit's (CMU) branded medicine contracting timetable.
- These arrangements do **not** apply to medicines funded via the National Cancer Drugs Fund (CDF).

NHS England Specialised Commissioning Medicines Optimisation CRG
January 2014